

Facility Name & ID Number Albany Care Inc

0037762 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	417	Intermediate (ICF)	417	152,622	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	417	TOTALS	417	152,622	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	138,225	1,148	991	140,364	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	138,225	1,148	991	140,364	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.97%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?

2,873 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1/01/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/01/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	296,304	51,258	64,140	411,702		411,702	(37,714)	373,988			1
2	Food Purchase		448,270		448,270	(14,933)	433,337	(36)	433,301			2
3	Housekeeping	258,859	45,807		304,666		304,666	1,012	305,678			3
4	Laundry		25,139	24,297	49,436		49,436		49,436			4
5	Heat and Other Utilities			346,630	346,630		346,630	4,217	350,847			5
6	Maintenance	75,554	26,181	164,505	266,240		266,240	(39,334)	226,906			6
7	Other (specify):*							10,866	10,866			7
8	TOTAL General Services	630,717	596,655	599,572	1,826,944	(14,933)	1,812,011	(60,990)	1,751,021			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,340,769	56,535	183,183	2,580,487		2,580,487	(63,641)	2,516,846			10
10a	Therapy	30,652	1,320	37,032	69,004		69,004	(15,160)	53,844			10a
11	Activities	382,249	19,355		401,604		401,604		401,604			11
12	Social Services	479,791		4,452	484,243		484,243		484,243			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							11,555	11,555			15
16	TOTAL Health Care and Programs	3,233,461	77,210	228,267	3,538,938		3,538,938	(67,246)	3,471,692			16
	C. General Administration											
17	Administrative	177,553		722,155	899,708		899,708	(411,771)	487,937			17
18	Directors Fees											18
19	Professional Services			227,606	227,606	(2,747)	224,859	(167,453)	57,406			19
20	Dues, Fees, Subscriptions & Promotions			81,754	81,754		81,754	(11,528)	70,226			20
21	Clerical & General Office Expenses	330,564	97,207	143,418	571,189		571,189	(56,731)	514,458			21
22	Employee Benefits & Payroll Taxes			630,445	630,445	14,933	645,378	(7,415)	637,963			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,700	6,700		6,700	(1,518)	5,182			24
25	Other Admin. Staff Transportation			22,339	22,339		22,339	(723)	21,616			25
26	Insurance-Prop.Liab.Malpractice			331,973	331,973		331,973	2,674	334,647			26
27	Other (specify):*							67,249	67,249			27
28	TOTAL General Administration	508,117	97,207	2,166,390	2,771,714	12,186	2,783,900	(587,215)	2,196,684			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,372,295	771,072	2,994,229	8,137,596	(2,747)	8,134,849	(715,452)	7,419,397			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			177,943	177,943		177,943	439,548	617,491			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93,662	93,662		93,662	991,111	1,084,773			32
33	Real Estate Taxes			471,177	471,177	2,747	473,924	11,730	485,654			33
34	Rent-Facility & Grounds			1,738,491	1,738,491		1,738,491	(1,738,491)				34
35	Rent-Equipment & Vehicles			23,525	23,525		23,525	9,854	33,379			35
36	Other (specify):*							19,852	19,852			36
37	TOTAL Ownership			2,504,798	2,504,798	2,747	2,507,545	(266,396)	2,241,149			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			228,934	228,934		228,934		228,934			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			228,934	228,934		228,934		228,934			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,372,295	771,072	5,727,961	10,871,328		10,871,328	(981,848)	9,889,480			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	196,677	30		9
10	Interest and Other Investment Income	(74)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(36)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,725)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,759)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(23,307)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(455)	20		28
29	Other-Attach Schedule	(92,722)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 63,599		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,045,447)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,045,447)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (981,848)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Albany Care Inc

ID#	0037762
Report Period Beginning:	01/01/04
Ending:	12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Rental Income	\$ (243)	10	1
2	Prescription Drugs-VA	(10,038)	10	2
3	Purchased Services-VA	(2,311)	10	3
4	Advertising & Promotion	(2,640)	20	4
5	Jury Duty Income	(86)	10	5
6	Cope Dues	(6,453)	20	6
7	Out of Period Legal Fees	(6,242)	19	7
8	Legal Fees - Collection	(767)	19	8
9	Capitalized R & M	(5,561)	06	9
10	Directors Fees - Norman Matthew	(30,000)	17	10
11	Non-Allowable Fees	(28,381)	21	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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98				98
99				99
100				100
101	Total	(92,722)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary					(29,270)	(8,444)						(37,714)	1
2	Food Purchase	(36)											(36)	2
3	Housekeeping			1,012									1,012	3
4	Laundry													4
5	Heat and Other Utilities			1,326	2,891								4,217	5
6	Maintenance	(5,561)		966	(24,386)	648	(10,940)		(62)				(39,334)	6
7	Other (specify):*				1,961	2,781	6,124						10,866	7
8	TOTAL General Services	(5,597)		3,304	(19,534)	(25,841)	(13,260)		(62)				(60,990)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(12,678)			(45,768)				(5,195)				(63,641)	10
10a	Therapy						(15,160)						(15,160)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				6,971		4,584						11,555	15
16	TOTAL Health Care and Programs	(12,678)			(38,797)		(10,576)		(5,195)				(67,246)	16
	C. General Administration													
17	Administrative	(30,000)		26,007	(32,852)	(359,326)	(15,600)						(411,771)	17
18	Directors Fees													18
19	Professional Services	(7,009)		(155,653)	670	28,319	(33,780)						(167,453)	19
20	Fees, Subscriptions & Promotions	(12,273)		319	426								(11,528)	20
21	Clerical & General Office Expenses	(65,447)	371	89,723	(16,066)	880	(66,192)						(56,731)	21
22	Employee Benefits & Payroll Taxes						(6,600)	(805)		(10)			(7,415)	22
23	Inservice Training & Education													23
24	Travel and Seminar			254	628		(2,400)						(1,518)	24
25	Other Admin. Staff Transportation			874	4,403		(6,000)						(723)	25
26	Insurance-Prop.Liab.Malpractice			634	1,393	647							2,674	26
27	Other (specify):*			15,373	8,215	43,661							67,249	27
28	TOTAL General Administration	(114,729)	371	(22,469)	(33,183)	(285,818)	(130,572)	(805)		(10)			(587,215)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(133,004)	371	(19,165)	(91,514)	(311,659)	(154,408)	(805)	(5,257)	(10)			(715,452)	29

STATE OF ILLINOIS

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	196,677	234,182	3,133	5,556								439,548 30
31	Amortization of Pre-Op. & Org.												
32	Interest	(74)	988,760	567	1,858								991,111 32
33	Real Estate Taxes			3,415	8,315								11,730 33
34	Rent-Facility & Grounds		(1,738,491)										(1,738,491) 34
35	Rent-Equipment & Vehicles			3,293	3,391	10,370	(7,200)						9,854 35
36	Other (specify):*		19,852										19,852 36
37	TOTAL Ownership	196,603	(495,697)	10,408	19,120	10,370	(7,200)						(266,396) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												
39	Ancillary Service Centers												
40	Barber and Beauty Shops												
41	Coffee and Gift Shops												
42	Provider Participation Fee												
43	Other (specify):*												
44	TOTAL Special Cost Centers												
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	63,599	(495,326)	(8,757)	(72,394)	(301,290)	(161,608)	(805)	(5,257)	(10)			(981,848) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,738,491	Albany Care, LLC		\$	(1,738,491)	1
2	V	36	Amortization				19,852	19,852	2
3	V	30	Depreciation				234,182	234,182	3
4	V	32	Mortgage Interest				990,273	990,273	4
5	V	21	Office Expense				371	371	5
6	V	33	Real Estate Taxes						6
7	V	32	Interest Income	1,513				(1,513)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,740,004			\$ 1,244,678	\$ * (495,326)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 1,012	\$ 1,012	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	1,326	1,326	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	966	966	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	26,007	26,007	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	2,101	2,101	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	319	319	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	89,723	89,723	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	254	254	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	874	874	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	634	634	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	15,373	15,373	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	3,133	3,133	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	567	567	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	3,415	3,415	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	3,293	3,293	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	157,754	PREFERRED BOOKKEEPING	100.00%		(157,754)	32
33	V	19	COMPUTER	10,008	PREFERRED BOOKKEEPING	100.00%	10,008		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 167,762			\$ 159,005	\$ * (8,757)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 2,891	\$ 2,891	15
16	V	6 REPAIRS AND MAINT.	37,536	S.I.R. MANAGEMENT, INC.	100.00%	13,150	(24,386)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,961	1,961	17
18	V	10 NURSING	82,572	S.I.R. MANAGEMENT, INC.	100.00%	36,804	(45,768)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	6,971	6,971	19
20	V	17 ADMINISTRATIVE	52,548	S.I.R. MANAGEMENT, INC.	100.00%	19,696	(32,852)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	670	670	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	426	426	22
23	V	21 CLERICAL & GENERAL	42,540	S.I.R. MANAGEMENT, INC.	100.00%	26,474	(16,066)	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	628	628	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	4,403	4,403	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,393	1,393	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	8,215	8,215	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	5,556	5,556	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	1,858	1,858	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	8,315	8,315	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	3,391	3,391	31
32	V							32
33	V	39 LEASED EQUIPMENT		S.I.R. MANAGEMENT, INC.	100.00%			33
34	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%			34
35	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%			35
36	V							36
37	V							37
38	V							38
39	Total		\$ 215,196			\$ 142,802	\$ * (72,394)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 DIETARY SALARIES	\$ 42,540	S.I.R. MANAGEMENT, INC.	100.00%	\$ 13,270	\$ (29,270)	15
16	V	7 EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	2,781	2,781	16
17	V	17 ADMIN./LEGAL SALARIES	592,263	S.I.R. MANAGEMENT, INC.	100.00%	97,242	(495,021)	17
18	V	19 FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	28,319	28,319	18
19	V	27 EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	15,261	15,261	19
20	V							20
21	V	17 ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	68,896	68,896	21
22	V	6 REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	648	648	22
23	V	21 CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	632	632	23
24	V	26 AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	325	325	24
25	V	27 EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	14,238	14,238	25
26	V	35 AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	7,374	7,374	26
27	V							27
28	V	17 ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	66,798	66,798	28
29	V	21 CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	248	248	29
30	V	26 AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	322	322	30
31	V	27 EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	14,163	14,163	31
32	V	35 AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	2,995	2,995	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 634,803			\$ 333,513	\$ * (301,290)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	SPECIAL REHAB	37,032	S.I.R. MANAGEMENT, INC.	100.00%	21,872	\$ (15,160)	15
16	V	15	EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	4,584	4,584	16
17	V								17
18	V	6	REPAIRS AND MAINT.	22,536	S.I.R. MANAGEMENT, INC.	100.00%	16,996	(5,540)	18
19	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	3,367	3,367	19
20	V								20
21	V								21
22	V	1	DIETICIAN SALARIES	21,600	S.I.R. MANAGEMENT, INC.	100.00%	13,156	(8,444)	22
23	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,757	2,757	23
24	V								24
25	V	19	LEGAL FEES	33,780	S.I.R. MANAGEMENT, INC.	100.00%		(33,780)	25
26	V								26
27	V	17	FEES	15,600	S.I.R. MANAGEMENT, INC.	100.00%		(15,600)	27
28	V								28
29	V	21	TELEPHONE & OFFICE	66,192	S.I.R. MANAGEMENT, INC.	100.00%		(66,192)	29
30	V	6	REPAIRS	5,400	S.I.R. MANAGEMENT, INC.	100.00%		(5,400)	30
31	V	35	EQUIPMENT RENTAL	3,000	S.I.R. MANAGEMENT, INC.	100.00%		(3,000)	31
32	V	35	AUTO LEASE	4,200	S.I.R. MANAGEMENT, INC.	100.00%		(4,200)	32
33	V	25	TRAVEL	6,000	S.I.R. MANAGEMENT, INC.	100.00%		(6,000)	33
34	V	24	SEMINARS	2,400	S.I.R. MANAGEMENT, INC.	100.00%		(2,400)	34
35	V	22	EMPLOYEE BENEFITS	6,600	S.I.R. MANAGEMENT, INC.	100.00%		(6,600)	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 224,340			\$ 62,732	\$ * (161,608)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 148,245	\$ 148,245	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	149,050	CCS EMPLOYEE BENEFIT GROUP	100.00%		(149,050)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 149,050			\$ 148,245	\$ * (805)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	\$	XCEL MEDICAL SUPPLY, LLC	100.00%	\$	\$	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING		XCEL MEDICAL SUPPLY, LLC	100.00%			17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE	415	XCEL MEDICAL SUPPLY, LLC	100.00%	353	(62)	19
20	V	10	NURSING	35,018	XCEL MEDICAL SUPPLY, LLC	100.00%	29,823	(5,195)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39	ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%			25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 35,433			\$ 30,176	\$ * (5,257)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	HEALTH INSURANCE	\$ 20,600	ECM OWNERS COUNCIL	100.00%	\$ 20,746	\$ 146	15
16	V	17	ADMINISTRATOR SALARY	4,800	ECM OWNERS COUNCIL	100.00%	4,800		16
17	V	22	PAYROLL TAXES	600	ECM OWNERS COUNCIL	100.00%	444	(156)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 26,000			\$ 25,990	\$ * (10)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Louise Bergthold	Shareholder	Administrative	0.72%	See Attached	11.37	20.67%	Alloc.Sal	\$ 36,368	17-7	1
2	Patricia McDiarmid	Shareholder	Administrative	0.48%	See Attached	10.34	20.68%	Alloc.Sal	19,696	17-7	2
3	Jeff Oravec	Shareholder	Administrative	0.48%	See Attached	8.27	20.67%	Alloc.Sal	20,015	17-7,21-7	3
4	Thomas Winter	Shareholder	Administrative	0.72%	See Attached	9.64	16.07%	Alloc Sal/Mgt	56,007	17-7,17-3	4
5	Bryan Barrish	Shareholder	Administrative	4.98%	See Attached	13.30	33.25%	Alloc Sal	68,897	17-7	5
6	Mike Giannini	Shareholder	Administrative	4.98%	See Attached	13.30	33.25%	Alloc Sal	66,798	17-7	6
7	Nenita Guzman	Relative	Dietary	0	See Attached	10.34	20.68%	Alloc Sal	13,270	1-7	7
8	Dennis Tossi	Shareholder	Administrative	3.12%	none	40.00	100.00%	Salary	116,948	17-1	8
9	Eric Rothner	Shareholder	Administrative	4.56%	See Attached	1.59	3.45%	Alloc Sal/Mgt	21,067	17-7, 17-3	9
10	Adam Vales	Relative	Clerical	0	See Attached	0.97	2.43%	Alloc Sal	1,000	22-7	10
11											11
12											12
13								TOTAL	\$ 420,066		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

PREFERRED BOOKKEEPING SERVICES

Street Address

4100 WEST PRATT AVE.

City / State / Zip Code

LINCOLNWOOD, IL. 60712

Phone Number

(847) 674-5200

Fax Number

(847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	927,958	10	\$ 5,955	\$	157,754	\$ 1,012	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	927,958	10	7,801		157,754	1,326	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	927,958	10	5,680		157,754	966	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	927,958	10	152,983	152,983	157,754	26,007	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	927,958	10	12,360		157,754	2,101	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	927,958	10	1,874		157,754	319	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	927,958	10	527,777	466,233	157,754	89,723	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	927,958	10	1,493		157,754	254	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	927,958	10	5,142		157,754	874	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	927,958	10	3,729		157,754	634	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	927,958	10	90,428		157,754	15,373	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	927,958	10	18,431		157,754	3,133	12
13	32	INTEREST	BOOK./ACCNT.INCOME	927,958	10	3,338		157,754	567	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	927,958	10	20,087		157,754	3,415	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	927,958	10	19,368		157,754	3,293	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						10,008	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 876,446	\$ 619,216		\$ 159,005	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	PATIENT DAYS	678,909	11	\$ 13,981	\$	140,364	\$ 2,891	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	678,909	11	63,606	46,253	140,364	13,150	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	678,909	11	9,483		140,364	1,961	3
4	10	NURSING	PATIENT DAYS	678,909	11	178,013	178,013	140,364	36,804	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	678,909	11	33,716		140,364	6,971	5
6	17	ADMINISTRATIVE	PATIENT DAYS	678,909	11	95,266	95,266	140,364	19,696	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	678,909	11	3,242		140,364	670	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	678,909	11	2,062		140,364	426	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	678,909	11	128,049	90,910	140,364	26,474	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	678,909	11	3,040		140,364	628	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	678,909	11	21,297		140,364	4,403	11
12	26	INSURANCE	PATIENT DAYS	678,909	11	6,736		140,364	1,393	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	678,909	11	39,734		140,364	8,215	13
14	30	DEPRECIATION	PATIENT DAYS	678,909	11	26,873		140,364	5,556	14
15	32	INTEREST	PATIENT DAYS	678,909	11	8,988		140,364	1,858	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	678,909	11	40,220		140,364	8,315	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	678,909	11	16,401		140,364	3,391	17
18										18
19	39	LEASED EQUIPMENT	LEASING INCOME	52,560	1					19
20	30	DEPRECIATION	LEASING INCOME	52,560	1	24,293				20
21	32	INTEREST	LEASING INCOME	52,560	1	6,298				21
22										22
23										23
24										24
25	TOTALS					\$ 721,298	\$ 410,443		\$ 142,802	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

S.I.R. MANAGEMENT, INC.

Street Address

6840 N. LINCOLN

City / State / Zip Code

LINCOLNWOOD, IL. 60712

Phone Number

(847) 675 -7979

Fax Number

(847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	678,909	11	\$ 64,183	\$ 64,183	140,364	\$ 13,270	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	678,909	11	13,453		140,364	2,781	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	678,909	11	470,339	470,339	140,364	97,242	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	678,909	11	136,972		140,364	28,319	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	678,909	11	73,815		140,364	15,261	5
6										6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	30	4	155,406	155,406	13	68,896	7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	30	4	1,462		13	648	8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	30	4	1,426		13	632	9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	30	4	733		13	325	10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	30	4	32,115		13	14,238	11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	30	4	16,634		13	7,374	12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	150,673	150,673	13	66,798	14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	4	560		13	248	15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	4	726		13	322	16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	31,946		13	14,163	17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	6,756		13	2,995	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,157,199	\$ 840,601		\$ 333,513	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 63,630	\$ 63,630	37,032	\$ 21,872	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,337		37,032	4,584	2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	143,028	11	107,866	107,866	22,536	16,996	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	143,028	11	21,371		22,536	3,367	5
6										6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	76,377	76,377	21,600	13,156	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	16,008		21,600	2,757	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 298,589	\$ 247,873		\$ 62,732	25

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/04

Name of Related Organization	<u>CCS EMPLOYEE BENEFITS GROUP, INC.</u>
Street Address	<u>4101 W. MAIN ST.</u>
City / State / Zip Code	<u>SKOKIE, IL 60076</u>
Phone Number	<u>(847)905-4000</u>
Fax Number	<u>(847)905-4040</u>

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 148,245	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 148,245	25

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization XCEL MEDICAL SUPPLY, LLC
Street Address 2201 MAIN STREET
City / State / Zip Code EVANSTON, IL 60202
Phone Number (847)328-7600
Fax Number (847)328-7615

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			\$	\$		\$	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation							3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						353	5
6	10	NURSING	Direct Allocation						29,823	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation							10
11	39	ANCILLARY	Direct Allocation							11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 30,176	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization ECM OWNERS COUNCIL
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL 60646
Phone Number (847)676-2026
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	HEALTH INSURANCE	DIRECT ALLOCATION		4	\$	\$		20,746	1
2	17	ADMINISTRATOR SALARY	DIRECT ALLOCATION		4				4,800	2
3	22	PAYROLL TAXES	DIRECT ALLOCATION		4				444	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		25,990	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/04

Fax Number

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Nomura		X	Mortgage	\$103,874.00	11/20/95	\$ 12,500,000	\$ 10,843,310	12/01/20	8.8800	\$ 990,273	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	CIB Bank		X	Improvements				534,548		prime+1%	45,108	6
7	CIB Bank		X	Working Capital		06/20/03		2,450,000		prime-0.5%	48,554	7
8	See Supplemental Schedule										2,425	8
9	TOTAL Facility Related				\$103,874.00		\$ 12,500,000	\$ 13,827,858			\$ 1,086,360	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,587)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			\$ (1,587)	14
15	TOTALS (line 9+line14)						\$ 12,500,000	\$ 13,827,858			\$ 1,084,773	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$				\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8	Alloc. Preferred Bookkeeping		X				\$				\$	567	8						
9	Alloc. S.I.R. Management		X									1,858	9						
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											2,425	14						
	B. Non-Facility Related*																		
15							\$				\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											20							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<div>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</div>				
1. Real Estate Tax accrual used on 2003 report.			\$	441,600 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	454,707 2
3. Under or (over) accrual (line 2 minus line 1).			\$	13,107 3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	469,800 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	2,747 5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	485,654 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
1999	449,196	8	FOR OHF USE ONLY	
2000	457,691	9		
2001	423,570	10	13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
2002	430,657	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
2003	442,977	12	15	LESS REFUND FROM LINE 6 \$ 15
Accrual = 442,977 x 1.06 = 469,800 rounded			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Alloc. Preferred Bokkeeping \$3,415				
Alloc. S.I.R. Management \$8,315				

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Albany Care Inc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037762

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 11-19-121-019-0000	Long Term Care property	\$ 442,976.71	\$ 442,976.71
2. See Attached	S.I.R..Management Allocation	\$ 79,702.01	\$ 10,928.06
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 522,678.72	\$ 453,904.77

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Albany Care Inc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037762

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)		(B)		(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>		<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.				\$	\$
2.				\$	\$
3.				\$	\$
4.				\$	\$
5.				\$	\$
6.				\$	\$
7.				\$	\$
8.				\$	\$
9.				\$	\$
10.				\$	\$
TOTALS				\$	\$

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 211,753

B. General Construction Type: Exterior Brick Frame _____ Number of Stories 7

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: _____

2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____

4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>24,573</u>	<u>1991</u>	<u>\$ 84,558</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	24,573		\$ 84,558	3

SEE ACCOUNTANTS' COMPILATION REPORT

11/2/2005 2:14 PM

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1993		61,428		20	3,071	3,071	34,915	9
10	Various		1994		120,534		20	6,026	6,026	62,462	10
11	Various		1995		291,499		20	14,331	14,331	135,616	11
12	Various		1996		58,666		20	2,934	(2,934)	24,993	12
13	Various		1997		72,445		20	3,740	3,740	27,141	13
14	Various		1998		177,216		20	8,861	8,861	59,438	14
15	Various		1999		262,434		20	13,123	13,123	69,050	15
16	Various		2000		239,704		20	12,358	12,358	52,304	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)	7,326,459	234,182		366,855	132,673	4,831,144	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)	153,590	5,284		5,999	715	58,055	68
69	Financial Statement Depreciation		177,943			(177,943)		69
70	TOTAL (lines 4 thru 69)	\$ 8,763,975	\$ 417,409		\$ 437,298	\$ 14,021	\$ 5,355,118	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,763,975	\$ 417,409		\$ 437,298	\$ 19,889	\$ 5,355,118	1
2	Tile Flooring	2001	59,176		20	5,918	5,918	18,739	2
3	Tile Flooring	2001	2,887		20	289	289	914	3
4	Tile Flooring	2001	8,059		20	806	806	2,552	4
5	Electrical Work	2001	6,335		20	317	317	1,267	5
6	Lighting	2001	3,530		20	177	177	707	6
7	Hvac Work	2001	8,188		20	409	409	1,569	7
8	Hvac Work	2001	7,275		20	364	364	1,394	8
9	Boiler	2001	206,552		20	10,328	10,328	37,868	9
10	Elevator Work	2001	14,500		20	725	725	2,417	10
11	Bathroom Hvac	2001	4,394		20	220	220	696	11
12	Shower Renovation	2001	39,492		20	1,975	1,975	6,418	12
13	Overhead Garage	2001	1,735		20	87	87	304	13
14	Sewer Work	2001	1,725		20	86	86	302	14
15	Boiler Work	2001	2,967		20	148	148	494	15
16	Staircase	2001	2,860		20	143	143	560	16
17	Shower Renovation	2001			20				17
18	Bathroom/Elect Work	2001			20				18
19	Tile Flooring	2001	68,106		20	3,405	3,405	10,784	19
20	Bathroom Work	2001	3,222		20	161	161	644	20
21	Ceiling Light	2002	2,905		20	581	581	1,743	21
22	Flooring - Tile	2002	39,612		20	1,016	1,016	2,962	22
23	Carpeting	2002	163,275		20	4,187	4,187	11,513	23
24	Floor Patching	2002	22,740		20	583	583	1,603	24
25	Painting	2002	310,434		20	7,960	7,960	21,558	25
26	Lobby Remodeling	2002	41,277		20	1,058	1,058	2,161	26
27	Nurse Call	2002	4,756		20	122	122	361	27
28	Nurse Station	2002	78,247		20	2,006	2,006	5,601	28
29	Water Booster	2002	13,387		20	343	343	787	29
30	Water Pump Temp	2002	15,952		20	409	409	869	30
31	Elevator Work	2002	1,844		20	47	47	104	31
32	Handrail	2002	61,523		20	1,578	1,578	4,141	32
33	Window Treatments	2002	87,580		20	2,246	2,246	5,895	33
34	TOTAL (lines 1 thru 33)		\$ 10,048,510	\$ 417,409		\$ 484,992	\$ 67,583	\$ 5,502,045	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,048,510	\$ 417,409		\$ 484,992	\$ 67,583	\$ 5,502,045	1
2	Exhaust Fan	2002	5,257		20	526	526	1,533	2
3	Interior Doors	2002	21,987		20	2,199	2,199	6,413	3
4	Bathroom Partitions	2002	2,888		20	289	289	842	4
5	Door Hinges	2002	990		20	99	99	297	5
6	Fire Sentinel	2002	844		20	84	84	253	6
7	Tile Repairs	2002	1,303		20	130	130	391	7
8	Plaster Repairs	2002	1,192		20	119	119	328	8
9	Generator Repairs	2002	1,170		20	117	117	332	9
10	Pump And Motor	2002	1,480		20	148	148	370	10
11	Boiler Repairs	2002	1,756		20	146	146	341	11
12	Pump Repairs	2002	1,538		20	154	154	346	12
13	Boiler Repairs	2002	5,015		20	251	251	690	13
14	Elevator Work	2003	4,700		20	235	235	470	14
15	Garage Door	2003	1,955		20	196	196	391	15
16	Flooring	2003	54,803		20	2,740	2,740	4,795	16
17	Handrails	2003	7,291		20	1,458	1,458	2,552	17
18	Lobby Wallcovering	2003	5,219		20	261	261	304	18
19	Lobby Painting	2003	3,102		20	155	155	181	19
20	Hot Water Tank	2003	6,440		20	644	644	1,288	20
21	Kitchen Door	2003	4,839		20	968	968	1,210	21
22	Water Heater	2003	2,619		20	524	524	655	22
23	Elevator Car 2	2003	86,889		20	8,689	8,689	12,309	23
24	Elevator Car 1	2003	87,890		20	8,789	8,789	10,254	24
25	Lobby Renovation	2003	214,810		20	21,481	21,481	37,592	25
26	Drain Valve	2003	1,486		20	74	74	149	26
27	Pipe Repairs	2003	1,898		20	95	95	182	27
28	Motor & Pump	2003	1,031		20	52	52	95	28
29	Wall Corner Guards	2003	550		20	28	28	46	29
30	Cubicle Track	2003	582		20	29	29	36	30
31	Mini Blinds	2003	503		20	25	25	29	31
32	Cubicle Curtains	2003	137		20	7	7	7	32
33	Resident Blinds	2003	175		20	9	9	9	33
34	TOTAL (lines 1 thru 33)		\$ 10,580,849	\$ 417,409		\$ 535,713	\$ 118,304	\$ 5,586,735	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,580,849	\$ 417,409		\$ 535,713	\$ 118,304	\$ 5,586,735	1
2	Elevator Generator	2003	4,166		20	208	208	382	2
3	Elevator Work	2004	7,000		20	350	350	350	3
4	Bathroom Work	2004	6,850		20	343	343	343	4
5	Fire Alarm System	2004	13,600		20	623	623	623	5
6	Phone System	2004	26,585		20	997	997	997	6
7	Hvac Work	2004	3,497		20	146	146	146	7
8	Boiler Tanks	2004	4,200		20	175	175	175	8
9	Elevator Car 3	2004	84,927		20	3,539	3,539	3,539	9
10	Water Heater	2004	2,779		20	104	104	104	10
11	Water Heater	2004	1,241		20	47	47	47	11
12	Elevator Work	2004	2,924		20	110	110	110	12
13	Elevator Work	2004	1,717		20	64	64	64	13
14	Stairway Rails	2004	7,485		20	187	187	187	14
15	Bathroom Work	2004	3,975		20	66	66	66	15
16	Roof	2004	70,300		20	1,172	1,172	1,172	16
17	Boiler Tank	2004	6,640		20	138	138	138	17
18	Water Heater	2004	7,800		20	130	130	130	18
19	Roof	2004	13,525		20	169	169	169	19
20	Repair Collapsed Wall In Basement	2004	1,200		20	50	50	50	20
21	Exhaust Fan	2004	1,269		20	37	37	37	21
22	Hunter Douglas Miniblinds	2004	520		20	7	7	7	22
23	Miniblinds, Color Alabaster	2004	937		20	8	8	8	23
24	Parking Lot Ramp Pass Door	2004	1,635		20	14	14	14	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,855,621	\$ 417,409		\$ 544,397	\$ 126,988	\$ 5,595,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1991	1991	\$ 7,267,981	\$ 230,730		\$ 363,399	\$ 132,669	\$ 4,784,753	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Albany Care, LLC			1993	58,478	3,452	15	3,456	4	46,391	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
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53								53
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57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$7,326,459	\$234,182		\$366,855	\$132,673	\$4,831,144	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		S.I.R.Properties-S.I.R.Management	1993	1993	\$ 55,245	\$ 1,754	35	\$ 1,578	\$ (176)	\$ 18,152	4
5		S.I.R. Properties - Preferred Bookkeeping	1993	1993	22,687	720	35	648	(72)	7,454	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10		Allocated Preferred Bookkeeping		1997	28,333	634	20	1,417	783	11,063	10
11		Allocated Preferred Bookkeeping		1999	225	-	20	11	11	62	11
12		Allocated Preferred Bookkeeping		2000	1,421	-	20	71	(71)	314	12
13											13
14		Allocated S.I.R. Management		1993	23,728	661	20	1,176	515	14,117	14
15		Allocated S.I.R. Management		1994	74	-	20	5	5	74	15
16		Allocated S.I.R. Management		1995	542	-	20	27	27	255	16
17		Allocated S.I.R. Management		1999	2,577	-	20	129	129	672	17
18		Allocated S.I.R. Management		2000	1,556	-	20	78	78	365	18
19											19
20		Allocated S.I.R. Properties - S.I.R. Management		2002	219	-	20	11	11	27	20
21		Allocated S.I.R. Properties - S.I.R. Management		1999	7,000	700	20	350	(350)	1,925	21
22		Allocated S.I.R. Properties - S.I.R. Management		1998	3,345	335	20	167	(168)	1,087	22
23		Allocated S.I.R. Properties - S.I.R. Management		1997	208	21	20	10	(11)	88	23
24		Allocated S.I.R. Properties - S.I.R. Management		1994	526	13	20	26	13	276	24
25		Allocated S.I.R. Properties - S.I.R. Management		1993	896	5	20	45	40	515	25
26											26
27		Allocated S.I.R. Properties - Preferred Bookkeeping		2002	90	-	20	4	4	11	27
28		Allocated S.I.R. Properties - Preferred Bookkeeping		1999	2,875	287	20	144	(143)	791	28
29		Allocated S.I.R. Properties - Preferred Bookkeeping		1998	1,374	137	20	69	(68)	446	29
30		Allocated S.I.R. Properties - Preferred Bookkeeping		1997	85	9	20	4	(5)	36	30
31		Allocated S.I.R. Properties - Preferred Bookkeeping		1994	216	6	20	11	5	113	31
32		Allocated S.I.R. Properties - Preferred Bookkeeping		1993	368	2	20	18	16	212	32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$153,590	\$5,284		\$5,999	\$573	\$58,055	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 671,843	\$ 3,163	\$ 71,104	\$ 67,941	10	\$ 1,151,657	71
72	Current Year Purchases	35,595	243	1,991	1,748	10	1,991	72
73	Fully Depreciated Assets	700,544				10	700,544	73
74								74
75	TOTALS	\$ 1,407,982	\$ 3,406	\$ 73,095	\$ 69,689		\$ 1,854,192	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	12,348,161
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	420,815
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	617,492
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	196,677
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	7,449,785

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 15,624
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	Facility	1997 Chevy Omni	354.00	607	18
19	Facility	2000 GMAC	564.00	6,778	19
20	Alloc. SIR management			10,369	20
21	TOTAL		\$ 918.00	\$ 17,754	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$
13.	/2006	\$
14.	/2007	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,338	\$ 10,600	1
2	Cash-Patient Deposits	49,020	49,020	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,122,330	3,592,130	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,082	7,082	6
7	Other Prepaid Expenses	9,185	9,185	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	160,117	160,117	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,355,072	\$ 3,828,134	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		84,558	13
14	Buildings, at Historical Cost		7,267,981	14
15	Leasehold Improvements, at Historical Cost	2,450,582	2,509,060	15
16	Equipment, at Historical Cost	2,025,538	2,025,538	16
17	Accumulated Depreciation (book methods)	(1,779,138)	(4,853,860)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		56,496	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,696,982	\$ 7,089,773	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,052,054	\$ 10,917,907	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 185,365	\$ 185,364	26
27	Officer's Accounts Payable	20,304	20,304	27
28	Accounts Payable-Patient Deposits	53,802	53,802	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	325,793	325,793	30
31	Accrued Taxes Payable (excluding real estate taxes)	46,226	516,026	31
32	Accrued Real Estate Taxes(Sch.IX-B)	469,800	469,800	32
33	Accrued Interest Payable	7,040	63,208	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	28,000	28,000	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	8,577	8,577	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,144,907	\$ 1,670,874	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,984,548	2,984,548	39
40	Mortgage Payable		10,843,310	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,984,548	\$ 13,827,858	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,129,455	\$ 15,498,732	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,922,599	\$ (4,580,825)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,052,054	\$ 10,917,907	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,601,658	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,601,658	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,321,741	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,000,800)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 320,941	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,922,599	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762Report Period Beginning: 01/01/04Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,192,666	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,192,666	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	74	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 74	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	329	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 329	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,193,069	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,826,944	31
32	Health Care	3,538,938	32
33	General Administration	2,771,714	33
	B. Capital Expense		
34	Ownership	2,504,798	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	228,934	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,871,328	40
41	Income before Income Taxes (line 30 minus line 40)**	1,321,741	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,321,741	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,857	2,091	\$ 106,283	\$ 50.83	1
2	Assistant Director of Nursing	3,867	4,218	93,510	22.17	2
3	Registered Nurses	2,831	3,121	73,874	23.67	3
4	Licensed Practical Nurses	35,362	37,846	836,172	22.09	4
5	Nurse Aides & Orderlies	109,245	116,291	1,128,727	9.71	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,849	4,206	30,652	7.29	8
9	Activity Director	3,651	3,986	59,560	14.94	9
10	Activity Assistants	34,788	37,408	322,689	8.63	10
11	Social Service Workers	31,762	34,389	479,791	13.95	11
12	Dietician					12
13	Food Service Supervisor	1,866	2,091	43,100	20.61	13
14	Head Cook	4,758	5,188	49,092	9.46	14
15	Cook Helpers/Assistants	21,371	23,221	204,112	8.79	15
16	Dishwashers					16
17	Maintenance Workers	5,078	5,361	75,554	14.09	17
18	Housekeepers	28,149	30,458	258,859	8.50	18
19	Laundry					19
20	Administrator	1,818	2,091	116,948	55.93	20
21	Assistant Administrator	2,830	2,950	60,605	20.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	33,768	36,249	330,564	9.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,730	6,404	102,203	15.96	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	332,580	357,569	\$ 4,372,295 *	\$ 12.23	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 64,140	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	Monthly	4,120	10-03	37
38	Nurse Consultant	Monthly	82,572	10-03	38
39	Pharmacist Consultant	Monthly	7,218	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	103	4,452	12-03	45
46	Other(specify)				46
47	Specialized Rehab	5,822	37,032	10A-03	47
48	Psychiatric Consultant	Monthly	3,600	10-03	48
49	TOTAL (lines 35 - 48)	5,925	\$ 206,734		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	15	\$ 480	10-03	50
51	Licensed Practical Nurses	2,278	85,193	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,293	\$ 85,673		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Dennis Tossi	Administrator	3.12	\$ 116,948
Dan Allegretti	Asst Admin.		45,266
Heather Eisner	Admin. In Training		15,339
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 177,553
B. Administrative - Other			
Description			Amount
Dir. Of Admin Services-S.I.R. Management			\$ 52,548
SIR Management Fees			15,600
Management Fees - S.I.R.			592,263
See Supplemetal Schedule			61,744
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 722,155
C. Professional Services			
Vendor/Payee	Type		Amount
LTC Solutions	Computer Services		\$ 1,320
Personnel Planners	Unemployment Tax Consult.		1,541
ICS Solutions	Internet Services		1,229
FR & R	Accounting		12,465
Preferred Bookkeeping	Accounting		27,650
Preferred Bookkeeping	Computer Services		10,008
Preferred Bookkeeping	Bookkeeping		130,104
S.I.R. Management	Legal Fees		33,780
Property Valuation Service	Appraisal Fee		2,500
Stuart Sikes	Collection Fees		622
Michael Best & Fredrich	Legal Fees(adj out pg 5A)		6,242
See Supplemetal Schedule			145
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 227,606
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 38,261
Unemployment Compensation Insurance			33,977
FICA Taxes			317,704
Employee Health Insurance			218,559
Employee Meals			14,933
Illinois Municipal Retirement Fund (IMRF)*			
401K Matching Contr.			10,241
Employee Benefits			4,288
TOTAL (agree to Schedule V, line 22, col.8)			\$ 637,963
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			21,191
Health Care Worker Background Check (Indicate # of checks performed 106)			747
Dues & Subscribtions			16,552
Licenses & Permits			30,991
Yellow Page Advertising			455
Alloc. Preferred Bookkeeping			319
Alloc. S.I.R. Management			426
Less: Public Relations Expense			()
Non-allowable advertising			()
Yellow page advertising			(455)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 70,226
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			4,300
Alloc. Preferred Bookkeeping			254
Alloc. S.I.R. Management			628
Entertainment Expense			()
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 5,182

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes
- (2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

ICLTC - \$19,253
- (3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 yrs
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 180

Line 10-2
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.

\$ 228,934

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 14,933

Has any meal income been offset against related costs?

No

Indicate the amount.

\$ N/A
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

None

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

No

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?

N/A

If no, please explain.

N/A
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT